104 CMR 27.03(2) is stricken and replaced with the following:

(2) Types of Licenses. Licensed mental health facilities shall be issued a single license which may incorporate one or more of the following classes; provided that no facility with Class II through VII licenses may use restraint or seclusion or administer electroconvulsive treatment without also having the applicable Class VIII or IX license.

(a) Class II. License to provide diagnosis and treatment of adults on voluntary admission status under M.G.L. c. 123, § 10.

(b) Class III. License to provide diagnosis and treatment of adults on conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7 and 8.

(c) Class IV. License to provide diagnosis and treatment of adults on involuntary committed status under M.G.L. c. 123, § 12.

(d) Class V. License to provide evaluation, diagnosis and treatment of patients committed by order of a criminal court to determine competency to stand trial or criminal responsibility or for treatment under M.G.L. c. 123, §§ 15, 16, 17 and 18.

(e) Class VI. License to provide diagnosis and treatment of minors on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12.

(f) Limited Class VI. License to provide diagnosis and treatment of minors age 16 and 17 on adult units on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§7, 8 and 12.

(g) Class VII. License to provide diagnosis and treatment of adolescents in an Intensive Residential Treatment Program (IRTP) on conditional voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and 8.

(h) Class VIII. License to use restraint and seclusion.

(i) Class IX. License to administer electroconvulsive treatment.

104 CMR 27.03(3) is stricken and replaced with the following:

(3) If a facility employs behavioral interventions for minors or adults, it shall meet the requirements of 104 CMR 27.10(7).

104 CMR 27.03(7) is stricken and replaced with the following:

(7) Additional Requirements for Class VI, Limited VI, and VII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VI, Limited VI, or VII shall comply with the following requirements.

(a) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Commissioner or designee. The plan shall include but not be limited to psychiatric, medical, nursing, social work and psychological services, family-focused treatment, occupational therapy, physical therapy if any, educational programs, recreational activities and equipment, and outdoor facilities.

(b) A child and adolescent psychiatrist certified or eligible to be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or the American Board of Adolescent Psychiatry shall provide on-site supervision of the care and treatment of patients in Class VI and VII facilities and shall be available for consultation and case supervision as needed for patients in Limited Class VI facilities.

(c) The facility shall have on its staff, or as consultants, a pediatrician and a pediatric neurologist, both of whom shall be fully licensed to practice medicine under Massachusetts law.

104 CMR 27.03(8) is stricken and replaced with the following:

`(8) Additional requirements for Class IX Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class IX shall comply with the following requirements:

(a) The facility shall establish a written plan for the administration of electroconvulsive treatment in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

(b) Monthly Reports. All facilities administering electroconvulsive treatment (ECT) to inpatients or outpatients shall maintain monthly reports on forms provided by the Department, which reports shall be available to the Department for inspection upon request.

104 CMR 27.03(9) is stricken and replaced with the following:

(9) Additional Requirements for Class VIII Facilities. In addition to complying with all applicable standards in this title, a facility to be licensed as Class VIII shall include the following in its application for a license or renewal of a license:

(a) the facility's plan to reduce and, wherever possible, eliminate restraint and seclusion as required by 104 CMR 27.12(1);
(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations, including 104 CMR 27.12, regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

104 CMR 27.03(10) is stricken and replaced with the following:

(10) Accreditation.
(a) A facility seeking a license as Class II, III, IV, V, VI, Limited VI, VIII, or IX, or any combination thereof, or a renewal of such license, shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accreditation agency approved by the Commissioner utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation shall be in substantial compliance with those standards, and must submit a plan for obtaining accreditation within a reasonable period of time.
(b) A facility seeking a license as Class VII, or a renewal of such license shall be accredited as a residential treatment program by JCAHO or other nationally recognized accreditation agency approved by the Commissioner. Facilities that have not yet attained accreditation must be in substantial compliance with the standards for residential treatment programs set forth by said Joint Commission or agency, and must submit a plan for obtaining accreditation within a reasonable period of time.

The introductory section of 104 CMR 27.03(11) is stricken and replaced with the following:

(11) Deemed Status. In addition to the Departmental action on license applications as set forth below, and any additional requirements for Class VII facilities set forth in 104 CMR 27.04, the Department may approve licensure of accredited facilities in accordance with the following requirements for deemed status.

Subsections (a) through (i) of 104 CMR 27.03(11) remain the same.

104 CMR 27.05(3) is stricken and replaced with the following:

(3) Admission Examination. Upon admission, each person shall receive a mental status examination and, within 24 hours of admission, a complete psychiatric and physical examination. In the case of admissions to an IRTP, such physical examination shall occur within seven days of admission. As part of the admission examination, staff shall seek to determine from the patient, the patient's record, the patient's legally authorized representative or, if appropriate and authorized, from other sources, whether the patient has a history of trauma, including but not limited to physical or sexual abuse or witnessing violence. At the completion of each admission examination, the physician shall make an admission diagnosis, and shall enter the findings of such admission examination in the patient's medical record.

104 CMR 27.11(1) is stricken and replaced with the following:

(1) Schedule of Periodic Reviews. Every facility shall conduct a periodic review of each inpatient upon admission, and for patients whose hospitalizations are expected to be at least 90 days, during the first three months, during the second three months, and annually thereafter until discharge, except that for facilities licensed as Class VI, Limited Class VI and VII and for units of Department facilities that admit patients under 19, such periodic reviews shall be conducted quarterly.

104 CMR 27.12 is stricken and replaced with the following:

27.12: Prevention of Restraint and Seclusion and Requirements When Used

(1) Prevention/Minimal Use of Restraint and Seclusion. A facility licensed as Class VIII shall develop and implement a plan to reduce and, wherever possible, eliminate the use of restraint and seclusion. The facility's plan shall include, at a minimum, the following:

(a) a posted statement of the facility's commitment to the prevention and minimal use of restraint and seclusion;

(b) policies and procedures that support the prevention and minimal use of restraint and seclusion;

(c) staff training that focuses on crisis prevention and de-escalation;

(d) programming and milieu that are consistent with the prevention and minimal use of restraint and seclusion;

(e) individually tailored sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure, weight or physical activity;

(f) the development and use of an individual crisis prevention plan for each patient;

(g) assessment of the impact of trauma experience and the potential for retraumatization;

(h) the regular use of debriefing activities;

(i) the process for addressing patient concerns and complaints about the use of restraint or seclusion;

(j) the use of data to monitor and improve quality and prevent and minimize the use of restraint and seclusion, such as identifying times or shifts with a high incidence of restraint or seclusion.

(2) Staff Training.

(a) A facility shall ensure that all unit staff receive training in the prevention and minimal use of restraint and seclusion during orientation, which shall be no later than one month after hire, and receive annual training thereafter. Training shall include, at a minimum, the following:

1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;
2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on individuals;
3. the impact of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization;
4. crisis prevention approaches and de-escalation strategies;
5. the use of the individual crisis prevention plan.

(b) In addition to the training in 104 CMR 27.12(2)(a), staff who may be involved in restraint or seclusion shall receive additional training, and annual

retraining thereafter. No staff shall be permitted to participate in any restraint or seclusion prior to receiving such additional training. Such training shall include, at a minimum, the following:

1. applicable legal and clinical requirements for restraint and seclusion;
2. the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion;
3. approaches to facilitate the earliest possible release from restraint or seclusion.

(c) Following initial training and each annual retraining, a facility shall require each staff member to demonstrate competencies in all areas of training. A facility shall maintain documentation of staff training and competencies.

(3) Individual Crisis Prevention Planning. A facility shall develop an individual crisis prevention plan for each patient.

(a) Definition. An individual crisis prevention plan is an age and developmentally appropriate, patient-specific plan that identifies triggers that signal or are likely to lead to agitation or distress in the patient and strategies to help the patient and staff intervene with tailored de-escalation techniques to reduce such agitation and distress and avoid the use of restraint and seclusion.

(b) Development of the Individual Crisis Prevention Plan. As soon as possible after admission, facility staff shall collaborate with each patient and his or her legally authorized representative, if any, and, where appropriate, with other sources, such as family members and caregivers, to complete and implement an individual crisis prevention plan. Relevant clinical data, including medical risk factors, physical disability, the patient's history of trauma, and, if available, the patient's health care proxy, shall inform the development of the plan. The plan shall include, at a minimum, the following elements:

1. identification of triggers that cause or signal agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
2. identification of particular approaches and strategies that are most helpful to the patient in reducing agitation or distress, such as environmental supports, physical activity, and sensory interventions;
3. in order to minimize trauma or retraumatization if restraint or seclusion is used, identification of the patient's preferences, such as type of intervention and positioning, gender of staff who administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

(c) The plan shall be updated as necessary to reflect changes in such triggers and strategies and shall be reviewed at each treatment plan review. If the patient is unable to participate in the initial development of the plan, staff shall make continuing efforts to include the patient's participation in review and revision of the plan. A facility shall ensure that all staff on all shifts are

aware of the individual crisis prevention plans for the patients in their care. A copy of the individual crisis prevention plan and any revisions thereto shall be placed in the patient record.

(4) Debriefing Activities. A facility shall develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it, and how to prevent future incidents. Debriefing shall always include those activities outlined in 104 CMR 27.12(4)(a) and (b) and shall, where applicable, include those activities outlined in 104 CMR 27.12(4)(c).

(a) Staff Debriefing. As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

1. identification of what led to the incident;
2. assessment of alternative interventions that may have avoided the use of restraint or seclusion;
3. determination of whether the patient's physical and psychological needs and right to privacy were appropriately addressed;
4. consideration of counseling or treatment for the involved patient and staff for any emotional or physical trauma that may have resulted from the incident;
5. consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
6. consideration of whether other patients and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
7. consideration of whether additional supervision or training should be provided to staff involved in the incident;
8. consideration of whether the incident should be referred for senior administrative or clinical staff review.

(b) Patient Debriefing. Within 24 hours after a patient's release from restraint or seclusion, the patient shall be asked to debrief and provide comment on the episode, including the circumstances leading to the episode, staff or patient actions that may have helped to prevent it, the type of restraint or seclusion used, and any physical or psychological effects he or she may be experiencing from the restraint or seclusion. Whenever possible and appropriate, the staff person providing the patient with the opportunity to comment shall not have been involved in the episode of restraint or seclusion. As part of the debriefing, the patient shall be provided with a copy of the restraint and seclusion order form required pursuant to 104 CMR 27.12(5)(i)1. with an attached patient debriefing and comment form approved by the Commissioner and shall be offered the opportunity to provide comment in writing. The staff person shall provide the patient with any necessary assistance in completing the Patient Debriefing and Comment Form. If the patient does not complete the form, but provides verbal or other

response to the episode, the staff person shall document such response on the form. If the patient provides verbal or other response to the episode at any other time, the staff person witnessing the response shall document it in writing. The patient debriefing and comment form or other documentation shall be attached to the restraint and seclusion order form and included in the patient record and copies of the form shall immediately be forwarded to the treatment team and the human rights officer. The patient shall also be notified of the availability of the complaint procedure outlined in 104 CMR 32.00. The human rights officer shall meet with a patient who has expressed a negative response to an episode of restraint or seclusion.

(c) Senior Administrative Review. The facility director shall ensure that senior administrative and clinical staff and other appropriate staff conduct a review if any of the following apply:

1. A patient or staff member experienced significant emotional or physical injury as a result of the episode.
2. The episode of restraint or seclusion exceeded six hours or episodes of restraint and/or seclusion for a patient exceeded 12 hours in the aggregate in any 48-hour period.
3. An exception to the restrictions on mechanical restraint of minors has occurred pursuant to 104 CMR 27.12(5)(e)1.d.
4. The episode appears to be part of a pattern warranting review.
5. The episode is marked by unusual circumstances.
6. The episode resulted in a complaint or reportable incident pursuant to 104 CMR 32.00.
7. the staff involved in the episode requested such a review pursuant to 104 CMR 27.12(4)(a)8.

Senior administrative review shall be conducted by the next business day following the identification of the episode and shall include, but not be limited to, assessment of the need for expert consultation, training, performance improvement activities, or change in policy.

(d) All debriefing activities shall be documented and included in the patient record and shall be used in treatment planning, revision of the individual crisis prevention plan, and ongoing restraint and seclusion prevention efforts.

(5) Requirements for the Use of Restraint and Seclusion.

(a) Definitions. For purposes of 104 CMR 27.12, the following definitions shall apply:

1. Authorized Physician. An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine patients in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.

2. Authorized Staff Person. An authorized staff person is any member of the licensed clinical staff at a facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant to 104 CMR 27.12(5)(e)2., and to assess for readiness for release and order release from restraint or seclusion.

3. Restraint. Restraint is a term that includes, for purposes of 104 CMR 27.00, medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limit freedom of movement. Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, protective helmets and supportive body bands, or other physical holding when necessary for routine physical examinations and tests or for orthopedic, surgical and other similar medical treatment purposes or when used to provide support for the achievement of functional body position or proper balance or to protect a patient from falling out of bed.

a. Medication Restraint. Medication restraint occurs when a patient is given medication involuntarily for the purpose of restraining the patient. Medication restraint shall not include:

i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(d) are complied with; or

ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

b. Mechanical Restraint. Mechanical restraint occurs when a physical device or devices are used to restrain a person by restricting the movement of a patient or the movement or normal function of a portion of his or her body.

c. Physical Restraint. Physical restraint occurs when a manual method is used to restrain a person by restricting a patient's freedom of movement or normal access to his or her body. Physical restraint may only include bodily holding of a patient with no more force than is necessary to limit the patient's movement. Physical restraint shall not include:

i. non-forcible guiding or escorting of a patient to another area of the facility;

ii. taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger;

iii. physical holding of a patient in accordance with 104 CMR 27.12(5)(a)3.b.;

iv. in the case of intensive residential treatment programs licensed pursuant to 104 CMR 27.04, briefly holding a patient without undue force in order to calm him or her; provided, however, that the facility shall document such brief holds in the patient record and consider the need for post-intervention review.

4. Seclusion. Seclusion occurs when a patient is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:

a manually, mechanically, or electrically locked doors, or "one-way doors," that, when closed and unlocked, cannot be opened from the inside;

b. physical intervention of staff;

c. coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.

Seclusion shall not include voluntary, collaborative separation from a group or activity for the purpose of calming a patient.

(b) Emergency Basis for Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion; Use of Individual Crisis Prevention Plan. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the individual crisis prevention plan, or after a determination that such alternatives would be inappropriate or ineffective under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition. The preferences in the patient's individual crisis prevention

plan, such as type of restraint or seclusion and gender of staff, shall be considered in ordering or initiating restraint or seclusion.

2. Duration of Medication Restraint, Mechanical Restraint, Physical Restraint, or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may only be used for the period of time necessary to accomplish its purpose but in no event beyond the periods established in 104 CMR 27.12(5)(e), (f) and (g).

3. PRN Orders Prohibited. No "PRN" or "as required" authorization of medication restraint, mechanical restraint, physical restraint or seclusion may be written.

4. Seclusion Used with Mechanical Restraint Prohibited. No patient shall be placed in seclusion while in mechanical restraints.

5. Other Requirements. When an emergency condition exists justifying the use of medication restraint, mechanical restraint, physical restraint or seclusion, such use must conform to all applicable requirements of 104 CMR 27.12.

(c) Physical and Mechanical Restraint or Seclusion - Physical Conditions.

1. Position in Physical or Mechanical Restraint. A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless there is a specified patient preference and no psychological or medical contra-indication to its use.

2. Personal Needs and Comfort. Provision shall be made for appropriate attention to the personal needs of the patient, including access to food and drink and toileting facilities, by staff escort or otherwise, and for the patient's physical and mental comfort.

3. Clothing. Patients in restraints shall be fully clothed, limited only by patient safety considerations related to the type of intervention used.

4. Physical Environment. The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions, such as adjusted lighting levels, where possible and appropriate.

5. Clock. Any space used for restraint or seclusion shall include a clock within visual observation of the patient, unless the patient indicates a contrary preference.

6. Seclusion - Observation. Any room used to confine a patient in seclusion must provide for complete visual observation of the patient so confined.

7. Mechanical Restraint – Locks Prohibited. No locked mechanical restraint devices requiring the use of a key for their release may be used.

(d) Medication Restraint – Order. A patient may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of (*i.e.*, at any time during the course of) the emergency justifying the use of the restraint or after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally

examined the patient, that such medication restraint is the least restrictive, most appropriate alternative available.

1. Such order along with the reasons for its issuance shall be recorded in writing at the time of its issuance.

2. Such order shall be signed at the time of its issuance by such authorized physician if present at the time of the emergency.

3. Such order, if authorized by telephone, shall be transcribed and signed at the time of its issuance by the physician, registered nurse or physician assistant who is present at the time of the emergency.

4. No medication may be used for medication restraint purposes pursuant to a telephoned order unless the medication so ordered has been previously prescribed for the patient.

5. An authorized physician shall conduct a face-to-face evaluation of the patient within one hour of the initiation of the restraint if the restraint was authorized by telephone.

(e) Initiation of Mechanical Restraint, Physical Restraint or Seclusion .

1. The order that a patient be placed in mechanical restraint, physical restraint, or seclusion shall be made by an authorized physician who is present when an emergency as defined in 104 CMR 27.12(5)(b) occurs.

a. Such order along with the reasons for its issuance shall be recorded in writing and signed at the time of its issuance by such physician.

b. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, subject to the additional requirements of 104 CMR 27.12(5)(e)1.d.

c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)9., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

d. No minor under age thirteen may be placed in mechanical estraint, except under the following conditions:

i. The patient's individual crisis prevention plan clearly states that the use of this type of restraint is indicated; or

ii. The facility medical director is notified prior to the use of such restraint or immediately after the initiation of the restraint, if an emergency as defined in 104 CMR 27.12(5)(b) occurs. The facility medical director shall inquire about the circumstances warranting the use of such restraint, the efforts made to de-escalate the situation, the alternatives to such restraint considered and tried, and whether other measures or resources might be helpful in avoiding the use of mechanical restraint or in facilitating early release.

iii. The facility director shall also be immediately informed of any such use of mechanical restraint and shall report it in writing to the Commissioner or designee by the next business day.

iv. All other applicable provisions of 104 CMR 27.12 shall be complied with.

2. If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a patient may be placed in mechanical restraint, physical restraint or seclusion at the initiation of an authorized staff person, subject to the following conditions and limitations;

a Such initiation along with the reasons for its issuance shall be recorded in writing and signed at the time of the incident by such authorized staff person.

b Such initiation shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)9., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

c. An authorized physician shall examine the patient within one hour of such initiation of mechanical restraint, physical restraint, or seclusion.

(f) Continuation of Mechanical Restraint or Seclusion for Additional One-Hour Periods.

Subsequent renewals of mechanical restraint or seclusion may be made for up to a one-hour period only if an authorized physician has examined the patient and ordered such renewal prior to the expiration of the preceding order, subject to the following conditions and limitations.

1. Such a renewal order may only be issued if the patient is an adult or minor over age nine and such physician determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).

2. Each such order shall be recorded in writing and signed by such physician, but only after examination of the patient in restraint or seclusion by such physician.

3. Each such order shall authorize continued use of restraint or seclusion for no more than one hour from the time of expiration of the preceding order, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)9., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

4. No such order for continuation beyond the initial order may be issued for physical restraint.

5. No such order for continuation of mechanical restraint or seclusion beyond the initial order may be issued if the patient is a minor under age nine and only one such order for continuation may be issued if the patient is a minor age nine through seventeen, subject to the additional limitations in 104 CMR 27.12(5)(g)2.

(g) Limitations on Duration of Restraint or Seclusion.

1. Minors under Age Nine. No minor under age nine may be in mechanical restraint, physical restraint or seclusion for more than one hour in any 24-hour period, subject to the additional requirements of 104 CMR 27.12(5)(e)1.d.

2. Minors Age Nine through 17. No minor age nine through 17 may be in mechanical restraint, physical restraint or seclusion for more than two hours in any 24-hour period, subject to the additional requirements of 104 CMR 27.12(5)(e)1.d.

3. Mechanical Restraint or Seclusion Exceeding Six Hours. If an episode of mechanical restraint or seclusion has exceeded five hours and it is expected that a new order will be issued to extend the episode beyond six hours, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release.

4. Mechanical Restraint or Seclusion Exceeding 12 Hours or Total Episodes Exceeding 12 Hours in a 48-Hour Period. If an episode of mechanical restraint or seclusion has exceeded 11 hours and it is expected that a new order will be issued to extend the episode beyond 12 hours, or if episodes of restraint and/or seclusion for a patient have exceeded 12 hours in the aggregate in any 48-hour period, the following shall occur:

a. The patient shall receive a physical examination.

b. The facility director and facility medical director shall be notified. The facility medical director shall inquire about the outcome of the measures identified pursuant to 104 CMR 27.12(5)(g)3., in the case of a continuous episode, and about the circumstances that resulted in the continued or multiple use of restraint or seclusion. The facility medical director shall take steps, including consultation with appropriate parties, to identify and implement strategies to facilitate release as soon as possible and/or eliminate the use of multiple episodes, such as psychopharmacological reevaluation or other consultation, assistance with communication, including interpreter services, and consideration of involving family members or other trusted individuals.

c. The episode(s) shall be reported to the Commissioner or designee by the next business day.

5. Release Prior to Expiration of Order. If a patient is released from restraint or seclusion prior to the expiration of an order and an emergency as defined in 104 CMR 27.12(5)(b) occurs prior to such order's expiration, but no later than one-half hour after release, the patient may be returned by an authorized staff person to restraint or seclusion without a new order for the time remaining in the order. Such return to restraint or seclusion shall be documented in the record. If the time permitted by the order or one-half hour has elapsed at the time of such emergency, the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(5)(e) shall be followed.

(h) Monitoring and Assessment of Patients in Mechanical Restraint, Physical Restraint or Seclusion; Release.

1. Authorized Staff Person in Charge. There shall be an authorized staff person with oversight responsibility during each episode of mechanical or physical restraint or seclusion.

2. One-on-One Staff Monitoring. Whenever a patient is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such person one-on-one.

3. The staff person conducting such monitoring may be immediately outside a space in which a patient is being secluded without mechanical restraint provided that the following conditions are met:

a. The staff person must be in full view of the patient (*e.g.*, the patient may approach the seclusion door and see the staff person through a window in the door if he or she wishes to do so); and

b. The staff person must be able at all times to observe the patient.

4. The staff person shall monitor a patient in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times. It is not necessary for a staff person monitoring a patient in mechanical or physical restraint to be in full view of the patient, although if such visibility has been expressed as a preference by the patient, consideration shall be given to honoring such preference.

5. Staff who monitor a patient in physical or mechanical restraint or seclusion shall continually assist and support the patient, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release pursuant to 104 CMR 27.12(5)(h)7. Such monitoring activities shall be documented every 15 minutes.

6. Staff who monitor a patient in restraint or seclusion shall continue appropriate interventions designed to calm the patient throughout the episode of restraint or seclusion.

7. Monitoring for Readiness for Release

a. Staff conducting monitoring shall continually consider whether a patient in mechanical restraint, physical restraint or seclusion appears ready to be released. If the staff person believes that the patient is ready to be released from such restraint or seclusion, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the patient for readiness to be released.

b. If a patient falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the patient from the restraint or seclusion, unless such efforts are reasonably expected to re-agitate the patient.

c. If, at any time during mechanical restraint, physical restraint, or seclusion, a patient is briefly released from such restraint or seclusion

to attend to personal needs pursuant to 104 CMR 27.12(5)(c)2. or for other purpose, staff conducting monitoring shall consider the patient's readiness to be permanently released, rather than returned to the restraint or seclusion, and notify an authorized staff person if the patient appears ready to be released.

8. Assessment. An authorized staff person or authorized physician shall assess a patient in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 30 minutes and at any other time that it appears that the patient is ready to be released. Such assessments shall be documented in the record.

9. Permanent Release. A patient shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the patient or consultation with staff that such mechanical restraint, physical restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) and, in no event, no later than the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed in accordance with the requirements or 104 CMR 27.12(5)(f). The circumstances considered in making such a determination shall be documented and signed by the authorized physician or authorized staff person making the determination.

(i) Documentation Requirements.

1. The Restraint and Seclusion Order Form. Each facility subject to these regulations shall ensure that a restraint and seclusion order form is maintained and completed on each occasion when a patient is placed and maintained in restraint or seclusion. The restraint and seclusion order form shall conform to the following requirements:

a. The restraint and seclusion order form must be in a form approved by the Commissioner.

b. The restraint and seclusion order form shall be completed in triplicate, one copy of which shall be placed in the patient's record, one copy of which shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy of which shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2.

c. Any attachments required by 104 CMR 27.12 shall be attached to each copy of the restraint and seclusion order form.

2. Submission to the Commissioner; Review. At the end of each month, a facility shall submit to the Commissioner or designee copies of all restraint and seclusion forms with attachments, if any, required by 104 CMR 27.12 and an aggregate report for each facility unit, on a form approved by the Commissioner, containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee shall review such aggregate reports and review a sample of

restraint and seclusion forms, and shall maintain statistical records of all uses of restraint or seclusion, organized by facility and unit.

3. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion order forms and attachments, if any, sent to the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2. shall be sent to the human rights committee of the facility, if operated by or under contract to the Department, and otherwise to the human rights officer, which shall review the use of all restraints by the facility or program. The committee or human rights officer shall have the authority to:

a. review all pertinent data concerning the behavior that necessitated restraint or seclusion;

b. obtain information about the patient's needs from appropriate staff, relatives and other persons with direct contact or special knowledge of the patient;

c. monitor the use of the individual crisis prevention plan and consider all less restrictive alternatives to restraint and seclusion in meeting the patient's needs; and

d. review and refer to the person in charge for action in accordance with 104 CMR 32.00 all complaints that the rights of a patient are being abridged by the use of restraint or seclusion and generally monitor the use of restraint and seclusion in the facility.